
Appendix A: National CEWG Members

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1232 East Broadway, Suite 120
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129 East Hanover Street CN 362
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E-mail:mhaight@aol.com

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Phone:(305) 757-2566/(305) 375-8032
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E-mail:jane_maxwell@tcada.state.tx.us

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Johnson, Bassin & Shaw, Inc.
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Fax:(301) 587-4352
E-mail:mmeth%nida1@ngmsmtp.samhsa.gov

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Fax:(504) 565-7886

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Chicago, IL 60612
Phone:(312) 996-4870
Fax:(312) 996-1450
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School of Public Health
University of Hawaii at Manoa
1960 East-West Road, T-102
Honolulu, HI 96822
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Appendix B: National CEWG Report Format

PATTERNS AND TRENDS OF DRUG ABUSE IN DRUGFREEVILLE: A REPORT THAT FOLLOWS THE CEWG OUTLINE

Daphne Data, Ph.D.
Stanley Statistic, Ph.D.
Alcohol and Drug Abuse Division
Drugfreeville Department of Health

Drugfreeville, Drugless State

The abstracts should be approximately 150 words in length. It should contain a general overall statement, followed by about 1 sentence for each drug category and for AIDS.

INTRODUCTION

1. Area Description

This short section describes factors unique to your city. It can include demographic, geographic, or socioeconomic factors. Include any factors that may be related to the drug abuse problem in the city.

2. Data Sources and Time Periods

This section should contain a series of bulleted items:

- **Source**—Describe the type of data. Explain any limitations and caveats. For each source, define two time periods: the latest reporting period and the comparison reporting period. If you use your State’s fiscal years, please define them.

- **Order**—If possible, try to sequence the data sources so they will conform to the following REVISED order:

1. Deaths
2. Emergency room mentions
3. Treatment admissions/ demographics
4. Drug Use Forecasting data (DUF)
5. Arrests/arrestee urinalyses
6. Availability, price, and purity
7. Seizures
8. Trafficking/distribution
9. Ethnographic information
10. Special studies (if available)

The “Data Sources and Time Periods” section might also provide a good opportunity to introduce exhibits; thus, exhibit order would also follow the outline.

DRUG ABUSE TRENDS

This introduction section is optional. If you choose to use it, please write no more than one or two paragraphs. Different authors use this section in different ways: some give data for overall drug use (combined data); some discuss just one major drug category or just one indicator; others describe data caveats or limitations.

1. Cocaine

The first paragraph often opens with an overall one-sentence statement about all the indicators (optional). It then talks about ethnographic data, if available.

Subsequently, each paragraph discusses one indicator. If a paragraph contains lots of data, or more than one source, you may want to split it into two paragraphs.

The order of the paragraphs is as follows: deaths; emergency room mentions; treatment admissions/demographics; DUF; arrests; availability, price, and purity; seizures; trafficking/distribution; ethnographic information special studies (if available).

You can also include paragraphs on special studies.

Don't forget to refer to your exhibits in your discussions.

2. Heroin

The above guidelines apply to all the drug categories in the Drug Abuse Trends section.

3. Other Opiates

For drug categories with fewer relevant data, you can combine several indicator discussions into one or two paragraphs.

4. Marijuana

5. Stimulants

6. Depressants

7. Hallucinogens

SPECIAL STUDIES

This section is optional if such data are available. Alternatively, you may choose to include this information in the

appropriate drug category discussions in the above Drug Abuse Trends section.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS (IDUs)

Please be sure to include the following numbers: Cumulative number of cases (compared to the figure from last report); percentage of cases that are both IDU and heterosexual; percentage of cases that are both IDU and homosexual/ bisexual.

If you give both State and city figures, please differentiate between the two for EVERY figure. Please be clear about whether or not your data include pediatric cases.

EXHIBITS

Please make sure each exhibit is numbered and titled.

- Include a SOURCE line on each exhibit.
- For graphs, please include a printout of your data points. If you are using the same graph as for your last report, **AND IF THE PREVIOUS DATA HAVE NOT CHANGED**, you can include only the data points from the most recent time periods.

Appendix C: Statistical Analysis Centers by State*

Alabama

Alabama Criminal Justice Information Center
770 Washington Avenue, Suite 350
Montgomery, AL 36130
(205) 242-4900

Alaska

The Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1810

Arizona

Arizona Criminal Justice Commission
1501 West Washington St.
Suite 207
Phoenix, AZ 85007
(602) 542-1928

Arkansas

Special Services Section
Arkansas Crime Information Center
One Capitol Mall, 4D200
Little Rock, AR 72201
(501) 682-2222

California

Office of Management Evaluation and Training
Law Enforcement Information Center
P.O. Box 903427
Sacramento, CA 94203-4270
(916) 227-3531

Colorado

Colorado Division of Criminal Justice
700 Kipling Street, Suite 1000
Denver, CO 80215
(303) 239-4453

Connecticut

Office of Policy and Management
Policy Development and Planning Division
80 Washington Street
Hartford, CT 06106
(203) 566-3522

Delaware

60 The Plaza
Dover, DE 19901
(302) 739-4846

District of Columbia

University of the District of Columbia
Department of Criminal Justice
4200 Connecticut Avenue NW
Washington, DC 20008
(202) 274-5687

Florida

Florida Department of Law Enforcement
P.O. Box 1489
Tallahassee, FL 32302
(904) 487-4808

Georgia

Statistical Analysis Bureau
Department of Criminal Justice
Georgia State University
P.O. Box 4018
Atlanta, GA 30302-4018
(404) 651-3515

Hawaii

Crime Prevention Division
Department of the Attorney General
City Center Building
810 Richards Street, Suite 701
Honolulu, HI 96813
(808) 586-1416

*SOURCE: Bureau of Justice Statistics, U.S. Department of Justice, Washington, D.C., September 1995.

Idaho

Support Services Bureau
Department of Law Enforcement
P.O. Box 700
Meridian, ID 83680-0700
(208) 884-7044

Illinois

Illinois Criminal Justice Information Authority
120 South Riverside Plaza
Suite 1016
Chicago, IL 60606

Indiana

Indiana Criminal Justice Institute
302 West Washington Street
Room E209
Indianapolis, IN 46204
(317) 232-1233

Iowa

Division of Criminal Justice and Juvenile
Planning
Lucas State Office Building
Des Moines, IA 50319
(515) 242-5816

Kansas

Kansas Criminal Justice Coordinating Council
Jayhawk Tower, Suite 501
700 Southwest Jackson
Topeka, KS 66603
(913) 296-0923

Kentucky

Office of the Attorney General
State Capitol Building
Frankfort, KY 40601
(502) 564-4002

Louisiana

Louisiana Commission on Law Enforcement
1885 Wooddale Boulevard, Suite 708
Baton Rouge, LA 70806
(504) 925-4440

Maine

Maine Criminal Justice Data Center
Department of Corrections
State House Station 111
Augusta, ME 04333
(207) 287-4343

Maryland

Maryland Justice Analysis Center
Institute of Criminal Justice and Criminology
College of Behavioral and Social
Sciences
2220 Samuel J. LeFrak Hall
University of Maryland
College Park, MD 20742-8235
(301) 405-4699

Massachusetts

Massachusetts Committee on Criminal Justice
100 Cambridge Street, Room 2100
Boston, MA 02202
(617) 727-0237

Michigan

Michigan State University
School of Criminal Justice
560 Baker Hall
East Lansing, MI 48824-1118
(517) 355-2197

Minnesota

Minnesota Planning Agency
Centennial Office Building, Room 300
658 Cedar Street
St. Paul, MN 55155
(612) 296-4852

Mississippi

Department of Criminal Justice Planning
301 West Pearl Street
Jackson, MS 39203
(601) 949-2225

Missouri

Information Systems Division
Missouri Highway Patrol
1510 East Elm
Jefferson City, MO 65102
(314) 751-4026

Montana

Board of Crime Control
Montana Department of Justice
303 North Roberts Street
4th Floor
Helena, MT 59620
(406) 444-4298

Nebraska

Commission on Law Enforcement & Criminal
Justice
P.O. Box 94946
Lincoln, NE 68509-4946
(402) 471-2194

Nevada

Nevada Highway Patrol
Records and Identification Services
555 Wright Way
Carson City, NV 89711-0525
(702) 687-5713

New Hampshire

Office of the Attorney General
33 Capitol Street
Concord, NH 03301
(603) 271-3658

New Jersey

Research and Evaluation
Department of Law and Public Safety
Hughes Justice Complex, CN-085
Trenton, NJ 08625
(609) 984-2737

New Mexico

Institute for Social Research
University of New Mexico
2808 Central Avenue SE
Albuquerque, NM 87106
(505) 277-4257

New York

Bureau of Statistical Services
Division of Criminal Justice Services
Executive Park Tower, Eighth Floor
Stuyvesant Plaza
Albany, NY 12203
(518) 457-8381

North Carolina

Criminal Justice Analysis Center
Governor's Crime Commission
3824 Barrett Drive, Suite 100
Raleigh, NC 27609-7220
(919) 571-4736

North Dakota

Information Services Section
Bureau of Criminal Investigation
4205 State Street
Bismarck, ND 58502-1054
(701) 221-5514

Ohio

Research and Statistics
Office of Criminal Justice Services
400 East Town Street, Suite 120
Columbus, OH 43215
(614) 466-0310

Oklahoma

Oklahoma Criminal Justice Resource Center
621 North Robinson, Suite 445
Oklahoma City, OK 73102
(405) 232-3328

Oregon

Criminal Justice Council
Statistical Analysis Center
155 Cottage Street NE
Salem, OR 97310
(503) 378-4123

Pennsylvania

Bureau of Statistics & Policy Research
Pennsylvania Commission on Crime
and Delinquency
P.O. Box 1167
Harrisburg, PA 17108
(717) 787-5152

Rhode Island

Governor's Justice Commission
222 Quaker Lane, Suite 100
Warwick, RI 02886
(401) 277-2620

South Carolina

Office of State and Grant Programs
Department of Public Safety
1205 Pendleton Street
Columbia, SC 29201
(803) 734-0423

South Dakota

Office of the Attorney General
500 East Capitol Avenue
Pierre, SD 57501
(605) 773-6310

Tennessee

Tennessee Bureau of Investigation
1148 Foster Avenue
Nashville, TN 37210-4406
(615) 726-7970

Texas

Criminal Justice Policy Council
P.O. Box 13332
Austin, TX 78711-3332
(512) 463-1810

Utah

Research Division
Commission on Criminal & Juvenile Justice
Room 101, Utah State Capitol
Salt Lake City, UT 84114
(801) 538-1059

Vermont

Vermont Center for Justice Research
33 College Street
Montpelier, VT 05602
(802) 828-8511

Virginia

Department of Criminal Justice Services
805 East Broad Street
Richmond, VA 23219
(804) 786-4000

Washington

Office of Financial Management
P.O. Box 43113
Olympia, WA 98504-3113
(360) 586-2501

West Virginia

Marshall University
Research & Economic Development Center
1050 Fourth Avenue
Huntington, WV 25755-8100
(304) 696-2718

Wisconsin

Office of Justice Assistance
222 State Street, 2nd Floor
Madison, WI 53702
(608) 266-7185

Wyoming

Division of Criminal Investigation
Office of the Attorney General
316 West 22nd Street
Cheyenne, WY 82002
(307) 777-7523

Northern Mariana Islands

Criminal Justice Planning Agency
Commonwealth Northern Mariana Islands
P.O. Box 1133
Saipan, MP 96950
(670) 322-9350

Puerto Rico

Criminal Justice Information System
Office of the Attorney General
P.O. Box 192
San Juan, PR 00902
(809) 729-2445

Virgin Islands

Law Enforcement Planning Commission
8172 Sub Base, Suite Three
St. Thomas, VI 00802-5803
(809) 774-6400

Appendix D: Method for Assessing Hospitalization Related to Drug and Alcohol Misuse by Youth and Young Adults

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Office of Epidemiology
Washington State Department of Health

Background

The Washington State Violence Reduction Programs Act of 1994 required the Washington State Department of Health to compile data on behaviors and related risk and protective factors which affect youth and their communities. These behaviors included violent behavior among youth, early pregnancy, dropping out of school, drug and alcohol abuse, suicide, child abuse, and domestic violence. The original data set was compiled in 1995 for defined geographic areas called Public Health and Safety Networks (Networks), which are roughly equivalent to counties or portions of counties. The Networks and Local Health Jurisdictions used the data to determine where to focus prevention efforts. We are currently in the process of updating the data to provide communities with information for ongoing assessment and program evaluation.

To assess the extent of alcohol and drug abuse, we developed community level data from a number of sources, including arrest data for drug and liquor law violations and driving under the influence of drugs or alcohol, alcohol- and drug-related traffic collisions; youth receiving State-sponsored alcohol and drug treatment; and alcohol- and drug-related hospital admissions. For the current update, we plan to use the following methodology to assess hospitalization of youth and young adults related to misuse of drugs and alcohol.

Methods

General considerations

1. Assign youth and young adults to the community based on zip code of residence, not location of hospital.
2. Count hospital discharges, not people. For example, a person who is discharged from the hospital for drug- or alcohol-related diagnoses twice in one year and three times in the following year will be counted twice in the first year and three times in the following year. While counting people is also a valid approach, we have chosen this approach partly because we are unable to unduplicate data we receive for Washington residents hospitalized in Oregon. More importantly, each hospitalization represents an adverse event which we would like to prevent; thus, each hospitalization is an event of public health importance.
3. Count each hospital discharge only once. Thus, a person hospitalized for both alcoholic psychosis and alcohol dependence syndrome will be counted only once for that hospitalization.
4. Count the occurrence of the ICD-9-CM codes in any of the diagnosis fields. From 1994–1996, approximately 37 percent of the alcohol- and drug-related codes specified below appeared as the first diagnosis. The remaining 63 percent appeared in secondary diagnosis fields.

An analysis of the first diagnosis for records where the drug or alcohol code appeared in the 2nd–9th diagnosis field revealed that approximately 85 percent of the first diagnoses were mental disorder codes (51 percent), complications of pregnancy (17 percent), or trauma (16 percent). If a substance abuse code appears with the complication of pregnancy or injury code, it is probably that the substance abuse is related to the hospitalization and, therefore, should be counted. We also want to count youth and young adults with comorbidities of substance abuse and mental disorders, since the substance abuse problem must be treated simultaneously with treatment for the mental disorder. In persons with the dual diagnosis of mental illness and substance abuse, it is also difficult to determine whether underlying mental disorder contributes to substance abuse or vice versa.

For the remaining 15 percent of records where the drug or alcohol diagnosis is in the 2nd to 9th diagnosis field, no group of diagnoses appears as the first diagnosis on more than 2 percent of records. For many of these diagnoses, it is highly likely that the drug or alcohol use contributed to the hospitalization.

Method of identifying records

1. Pull hospitalizations for people age 10 to 24 years at discharge.
2. Exclude all records with codes for suicide (E950–E959).
3. We have developed a 2-tiered approach which assigns each hospitalization with relevant ICD-9-CDM codes to definitely/probably or possibly related to drug and alcohol abuse. The ICD-9-CM codes are 3-digit numbers followed by up to 2 digits to the right of the decimal point. Unless otherwise specified, when we list the 3-digit code, we include any record with the 3-digit code, irrespective of the numbers after the decimal.

Likewise, when we list the code with 1 digit after the decimal, we include those codes with the same 4 numbers irrespective of the number in the 2nd space after the decimal. It is important to pull the records in the stepwise manner indicated so that records with appropriate codes are not excluded.

Codes for definite and probable drug and alcohol misuse

Step 1. Include any record meeting the age and nonsuicide criteria that has the following diagnoses in any of the diagnosis fields:

265.2	Alcoholic pellegra
291	Alcoholic psychoses
303	Alcohol Dependence Syndrome
304	Drug Dependence Syndrome
305.0,.2-9	Non-Dependent Abuse of Drugs
357.5	Alcoholic polyneuropathy
425.5	Alcoholic cardiomyopathy
535.3	Alcoholic gastritis
571.0–571.3	Alcohol-related liver disease
648.3	Drug dependence in pregnancy
790.3	Excess blood alcohol
965.00,.01	Poisoning by opium or heroin
969.6	Poisoning by psychodysleptics (hallucinogens)
980.0	Toxic effect of ethyl alcohol

Step 2. Include remaining records with the following diagnoses in any of the diagnosis fields and no concurrent diagnosis of E930–E949, adverse reactions to drugs, medicinal and biological substances in therapeutic use, properly administered and taken.

292	Drug psychoses
357.6	Polyneuropathy due to drugs

Codes for possible drug and alcohol abuse

Some codes in the series 960–979 (poisoning by drugs, medicinals, and biological substances) can include possible cases of drug

and alcohol misuse. According to the ICD-9-CM rules, this series specifically excludes drug dependence and nondependent abuse. However, for the specific codes in the 960–979 series listed below, we found that approximately 25 percent of the records have a concurrent diagnosis of drug dependence or nondependent abuse. The remaining 75 percent of records with these codes may represent:

- cases of dependence or abuse where the dependence or abuse is not mentioned on the discharge summary and, therefore, not coded as such;
- cases of youth experimenting with drugs, but not meeting the technical definition of dependence or abuse; or
- cases of medicines given or taken in error which have caused an adverse reaction.

We believe the first two types of records are of interest in assessing drug and alcohol misuse among youth, but that cases of medicines given or taken in error are not drug abuse. Since we cannot separate these latter cases, records where the only drug- or alcohol-related code is one of those shown below will be treated as possible cases of drug and alcohol abuse.

If the following codes appear as the only drug- or alcohol-related code, the record is counted as a possible case associated with misuse of drugs and alcohol.

Step 1. Include remaining records meeting the age and nonsuicide criteria that have the following diagnosis in any of the diagnosis fields:

305 Nondependent abuse of drugs when 4th digit is not specified

Step 2. Include remaining records meeting

the age and nonsuicide criteria with the following diagnoses in any of the diagnosis fields and no concurrent diagnosis of E930–E949, adverse reactions to drugs, medicinal, and biological substances in therapeutic use, properly administered and taken.

965.02,.09	Poisoning by methadone, other opiates and related narcotics
965.8	Poisoning by other specified analgesics and antipyretics (e.g., Pentazocine)
967	Poisoning by sedatives/hypnotics
968.5	Poisoning by topical anesthetics (cocaine and related compounds)
969	Poisoning by psychotropic agents when 4th digit is not specified
969.0-.5,.7-9	Poisoning by psychotropic agents (nonhallucinogens)
970	Poisoning by CNS stimulants

Use of external cause of poisoning or injury codes

We will not use external causes of poisoning or injury codes (E-codes) for selection of cases. E-codes described the circumstances under which someone is poisoned or injured. Because billing tends to be based on the medical condition and not the cause of the condition, E-codes are not as consistently recorded as other ICD-9-CM codes. (This needs to be remembered when interpreting the data, if codes have been specified as exclusion criteria.)

For most of the E-codes which might capture drug and alcohol abuse, we cannot distinguish poisonings related to abuse from those related to wrong drugs given or taken in error, accidents in the use of drugs during medical or surgical procedures, or accidental inhalation or ingestion.

E850.0 (accidental poisoning by heroin) and E860.0 (accidental poisoning by ethyl alcohol) may be exceptions. However, between 1994 and 1996 in the State of Washington data set, there were no records with E850.0 and only one record with E860.0 which did not also have one of the ICD-9-CM codes specified above. Therefore, omitting these E-codes does not substantively change hospitalization rates for drug and alcohol abuse. Between 1994 and 1996, there were 36 records with E-codes that might be related to drug and alcohol misuse among youth and young adults that were not identified using the rules specified above. This represents less than one-half of 1 percent of all hospitalizations captured using those rules.

Appendix E: State Contacts for Uniform Crime Reports*

Alabama

Alabama Criminal Justice Information
Center
Suite 350
770 Washington Avenue
Montgomery, Alabama 36130
(334) 242-4900

Alaska

Uniform Crime Reporting Section
Department of Public Safety Information
System
5700 East Tudor Road
Anchorage, Alaska 99507
(907) 269-5708

American Samoa

Department of Public Safety
Post Office Box 1086
Pago Pago
American Samoa 96799
(684) 633-1111

Arizona

Uniform Crime Reporting
Arizona Department of Public Safety
Post Office Box 6638
Phoenix, Arizona 85005
(602) 223-2263

Arkansas

Arkansas Crime Information Center
One Capitol Mall, 4D-200
Little Rock, Arkansas 72201
(501) 682-2222

California

Criminal Justice Statistics Center
Department of Justice
Post Office Box 903427
Sacramento, California 94203-4270
(916) 227-3470

Colorado

Uniform Crime Reporting
Colorado Bureau of Investigation
690 Kipling Street
Denver, Colorado 80215
(303) 239-4300

Connecticut

Uniform Crime Reporting Program
1111 Country Club Road
Post Office Box 2794
Middletown, Connecticut 06457-9294
(203) 685-8030

Delaware

State Bureau of Identification
Post Office Box 430
Dover, Delaware 19903
(302) 739-5875

District of Columbia

Information Services Division
Metropolitan Police Department
Room 5054
300 Indiana Avenue, Northwest
Washington, D.C. 20001
(202) 727-4301

Florida

Uniform Crime Reports Section
Florida Crime Information Center Bureau
Post Office Box 1489
Tallahassee, Florida 32302-1489
(904) 487-1179

Georgia

Georgia Crime Information Center
Georgia Bureau of Investigation
Post Office Box 370748
Decatur, Georgia 30037
(404) 244-2840

*Bureau of Justice Statistics, U.S. Department of Justice, Washington, D.C., September 1995.

Guam

Guam Police Department
Planning, Research and Development
Pedro's Plaza
287 West O'Brien Drive
Agana, Guam 96910
(671) 472-8911 x418

Hawaii

Chief of Research and Statistics
Crime Prevention Division
Department of the Attorney General
Suite 701
810 Richards Street
Honolulu, Hawaii 96813
(808) 586-1416

Idaho

Criminal Identification Bureau
Department of Law Enforcement
Post Office Box 700
Meridian, Idaho 83680
(208) 884-7156

Illinois

Uniform Crime Reporting Program
Illinois State Police
100 Illes Park Place
Post Office Box 3677
Springfield, Illinois 62704
(217) 782-5791

Iowa

Iowa Department of Public Safety
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-8494

Kansas

Kansas Bureau of Investigation
1620 Southwest Tyler Street
Topeka, Kansas 66612
(913) 296-8200

Kentucky

Information Services Branch
Kentucky State Police
1250 Louisville Road
Frankfort, Kentucky 40601
(502) 227-8783

Louisiana

Louisiana Commission on Law Enforcement
7th Floor
1885 Wooddale Boulevard
Baton Rouge, Louisiana 70806
(504) 925-4847
(504) 925-7730

Maine

Uniform Crime Reporting Division
Maine State Police
Station #42
36 Hospital Street
Augusta, Maine 04333
(207) 624-7003

Maryland

Central Records Division
Maryland State Police Department
1711 Belmont Avenue
Baltimore, Maryland 21244
(410) 298-3883

Massachusetts

Crime Reporting Unit
Massachusetts State Police
470 Worcester Road
Framingham, Massachusetts 01701
(508) 820-2110
(508) 820-2115

Michigan

Uniform Crime Reporting Section
Michigan State Police
7150 Harris Drive
Lansing, Michigan 48913
(517) 322-1150

Minnesota

Bureau of Criminal Apprehension
Minnesota Department of Public Safety
Suite 100-H, Town Square
1246 University Avenue
St. Paul, Minnesota 55104
(612) 642-0670
(612) 642-0610

Montana

Management Analyst
Montana Board of Crime Control
303 North Roberts
Helena, Montana 59620
(406) 444-2077

Nebraska

Uniform Crime Reporting Section
The Nebraska Commission on Law
Enforcement and Criminal Justice
Post Office Box 94946
Lincoln, Nebraska 68509
(402) 471-3982

Nevada

Criminal Information Services
Nevada Highway Patrol
555 Wright Way
Carson City, Nevada 89711
(702) 687-5713

New Hampshire

Uniform Crime Report
Division of State Police
10 Hazen Drive
Concord, New Hampshire 03305
(603) 271-2509

New Jersey

Uniform Crime Reporting
Division of State Police
Post Office Box 7068
West Trenton, New Jersey 08628-0068
(609) 882-2000 x2392

New York

Statistical Services
New York State Division of Criminal
Justice Services
8th Floor, Mail Room
Executive Park Tower Building
Stuyvesant Plaza
Albany, New York 12203
(518) 457-8381

North Carolina

Crime Reporting and Field Services
Division of Criminal Information
State Bureau of Investigation
407 North Blount Street
Raleigh, North Carolina 27601
(919) 733-3171

North Dakota

Information Services Section
Bureau of Criminal Investigation
Attorney General's Office
Post Office Box 1054
Bismarck, North Dakota 58502
(701) 328-5500

Oklahoma

Uniform Crime Reporting Section
Oklahoma State Bureau of Investigation
Suite 300
6600 North Harvey
Oklahoma City, Oklahoma 73116
(405) 879-2531

Oregon

Law Enforcement Data Systems Division
Oregon Department of State Police
400 Public Service Building
Salem, Oregon 97310
(503) 378-3057

Pennsylvania

Bureau of Research and Development
Pennsylvania State Police
1800 Elmerton Avenue
Harrisburg, Pennsylvania 17110
(717) 783-5536

Puerto Rico

Director of Statistics
Puerto Rico Police
Roosevelt Avenue 101
San Juan, Puerto Rico 00936
1-(787) 793-1234 ext. 3113

Rhode Island

Rhode Island State Police
311 Danielson Pike Post Office Box 185
North Scituate, Rhode Island 02857
(401) 444-1121

South Carolina

South Carolina Law Enforcement Division
Post Office Box 21398
Columbia, South Carolina 29221-1398
(803) 896-7022

South Dakota

South Dakota Statistical Analysis Center
500 East Capitol Avenue
Pierre, South Dakota 57501
(605) 773-6310

Texas

Uniform Crime Reporting Bureau
Crime Information Bureau
Texas Department of Public Safety
Post Office Box 4143
Austin, Texas 78765-4143
(512) 424-2091

Utah

Uniform Crime Reporting
Bureau of Criminal Investigation
Utah Department of Public Safety
4501 South 2700 West
Salt Lake City, Utah 84119
(801) 965-4445

Vermont

Vermont Crime Information Center
Post Office Box 189
Waterbury, Vermont 05676
(802) 244-8786

Virginia

Records Management Division
Department of State Police
Post Office Box 27472
Richmond, Virginia 23261-7472
(804) 674-2023

Virgin Islands

Records Bureau
Department of Public Safety
Post Office Box 210
Charlotte Amalie
Saint Thomas, Virgin Islands 00801
(809) 774-2211

Washington

Uniform Crime Reporting Program
Washington Association of Sheriffs and
Police Chiefs
Post Office Box 826
Olympia, Washington 98507
(360) 586-3221

West Virginia

Uniform Crime Reporting Program
West Virginia State Police
725 Jefferson Road
South Charleston, West Virginia 25309
(304) 746-2259

Wisconsin

Office of Justice Assistance
2nd Floor
222 State Street
Madison, Wisconsin 53703
(608) 266-3323

Wyoming

Uniform Crime Reporting
Criminal Records Section
Division of Criminal Investigation
316 West 22nd Street
Cheyenne, Wyoming 82002
(307) 777-7625

Appendix F-1: 1994 Drug-Related Arrests of Persons Over Age 17 by Age, Gender, and Race/Ethnicity—State of Maryland

	Gender	Age														Total	Race			
		18	19	20	21	22	23	24	25	30	35	40-44	45-49	50-54	55 & over		White	Black	Indian	Asian
Drug Abuse Laws	M	2,027	1,992	1,654	1,533	1,425	1,365	1,266	5,128	4,544	3,093	1,764	769	306	167	27,033	10,534	21,163	24	65
	F	165	175	173	161	179	187	218	1,087	1,073	787	352	124	40	32	4,753				
Drug Sales-Total	M	869	850	720	682	603	599	540	2,017	1,575	1,027	561	260	120	85	10,508	2,424	9,712	7	22
	F	53	64	64	71	77	66	80	402	353	236	114	41	14	22	1,657				
Opium or Cocaine and Derivatives	M	713	669	597	562	497	509	456	1,716	1,325	855	481	216	130	71	8,800	1,239	8,750	6	11
	F	37	41	33	50	59	49	61	307	262	169	84	31	8	15	1,206				
Marijuana	M	125	129	98	100	88	78	59	209	182	119	46	32	10	5	1,280	836	712	1	11
	F	12	20	26	15	15	10	14	57	45	35	19	5	5	2	280				
Synthetic Narcotics (Methadone, Demerol)	M	13	7	14	10	8	4	12	51	30	27	8	3	2	1	190	208	47		
	F	2	2	2	2	2	2	0	20	21	10	1	1	0	0	65	0	0		
Other Dangerous Non-Narcotic Drugs	M	18	15	11	10	10	8	13	41	28	26	26	9	5	8	238	141	203		
	F	2	1	3	4	1	5	5	18	25	22	10	4	1	5	106	0	0		
Drug Possession-Total	M	1,158	1,142	934	851	822	766	726	3,111	3,111	2,066	1,203	509	186	82	16,525	8,110	11,451	17	43
	F	112	111	109	90	102	121	138	685	685	551	238	83	26	10	3,096				
Opium or Cocaine and Derivatives	M	308	331	293	272	338	320	343	1,678	1,678	1,312	798	346	131	52	8,313	2,862	7,308	11	9
	F	30	28	37	45	48	71	78	446	446	379	167	49	16	5	1,877				
Marijuana	M	703	665	506	445	374	341	282	1,015	1,015	496	256	114	42	22	6,079	4,438	2,520	6	33
	F	77	70	69	41	43	44	39	177	177	117	47	23	7	2	918				
Synthetic Narcotics (Methadone, Demerol)	M	10	12	11	20	6	12	15	67	67	53	21	7	0	0	317	365	48		1
	F	3	3	0	0	4	2	7	21	21	22	3	3	0	0	97				
Other Dangerous Non-Narcotic Drugs	M	137	134	124	114	104	93	86	351	351	205	128	42	13	8	1,816	445	1,575		
	F	2	10	3	4	7	4	14	41	41	33	21	8	3	3	204				

SOURCE: Maryland State Police, 1996.

Appendix F-2: 1994 Drug-Related Arrests of Persons Under Age 18 by Age, Gender, and Race/ Ethnicity—State of Maryland

	Gender	09 and under	10-12	13-14	15	16	17	Total under 18	White	Black	Asian
Drug Abuse Laws	M	3	60	882	1,153	1,566	2,031	5,695	2,051	4,201	16
	F		15	92	114	146	206	573			
Drug Sales-Total	M	3	32	437	529	696	855	2,552	337	2,352	3
	F		3	22	25	31	59	140			
Opium or Cocaine and Derivatives	M	2	27	383	460	620	718	2,210	140	2,162	
	F		1	15	16	24	36	92			
Marijuana	M		5	46	60	61	112	284	144	172	2
	F		1	4	8	5	16	34			
Synthetic Narcotics (Methadone, Demorol)	M			6	4	12	10	32	21	15	1
	F			1	1	2	1	5			
Other Dangerous Non-Narcotic drugs	M	1		2	5	3	15	26	32	3	
	F		1	2			6	9			
Drug Possession-Total	M		28	445	624	870	1,176	3,143	1,714	1,849	13
	F		12	70	89	115	147	433			
Opium or Cocaine and Derivatives	M		11	180	227	293	367	1,078	162	992	1
	F		4	14	13	18	28	77			
Marijuana	M		17	226	373	544	773	1,933	1,410	831	12
	F		8	48	66	88	110	320			
Synthetic Narcotics (Methadone, Demorol)	M			4	7	7	4	22	35	2	
	F			3	2	4	6	15			
Other Dangerous Non-Narcotic drugs	M			35	17	26	32	110	107	24	
	F			5	8	5	3	21			

SOURCE: Maryland State Police, 1996.

Appendix G: DEA Division Offices

Aviation Operations Center

2300 Horizon Road
Ft. Worth, TX 76177-5300
(817) 837-2000

DEA Atlanta Division

75 Spring Street, S.W., Room 740
Atlanta, GA 30303
(404) 331-4407

DEA New England Division

50 Staniford Street, Suite 200
Boston, MA 02114
(617) 557-2100

DEA Carribbean Division

2434 Loiza Street
Santurce, PR 00913
(809) 253-4200

DEA Chicago Division

2300 S. Dearborn Street, Suite 1200
Chicago, IL 60604
(312) 353-7875

DEA Dallas Division

1880 Regal Row
Dallas, TX 75235
(214) 767-7151

DEA Detroit Division

431 Howard Street
Detroit, MI 48226
(313)234-4000

EPIC

11339 SSG Sims Street
El Paso, TX 79908-2033
(915) 564-2033

DEA Houston Division

333 West Loop North, Suite 300
Houston, TX 77024
(700) 527-9000

DEA Los Angeles Division

255 East Temple Street, 20th Floor
Los Angeles, CA 90012
(213) 894-2650

DEA Miami Division

8400 N.W. 53rd Street
Miami, FL 33166
(305)590-4870

DEA New Orleans Division

3 Lakeway Center
3838 N. Causeway Blvd., Suite 1800
Metairie, LA 70002
(504) 840-1100

DEA New York Division

99 Tenth Avenue
New York, NY 10011
(212) 337-3900

DEA Newark Division

970 Broad Street, Room 806
Newark, NJ 07102
(201) 645-6060

DEA Philadelphia Division

600 Arch Street, Room 10224
Philadelphia, PA 19106
(215) 597-9530

DEA Phoenix Division

3010 North 2nd Street, Suite 301
Phoenix, AS 85012
(602) 64-5600

DEA Rocky Mountain Division

115 Inverness Drive, East
Englewood, CO 80112-5116
(303) 784-6300

DEA San Diego Division

402 West 35th Street
National City, CA 91950
(619) 585-4200

DEA San Francisco Division

450 Golden Gate Ave.
San Francisco, CA 94102
(415) 556-6771

DEA Seattle Division

220 West Mercer, Suite 300
Seattle, WA 98119
(206) 553-5443

DEA St. Louis Division

7911 Forsythe Boulevard, Suite 500
St. Louis, MO 63105
(314) 425-3241

DEA Washington, D.C.

Division 400 Sixth Street, S.W., Room 2558
Washington, D.C. 20024
(202) 401-7834

Appendix H-1: Excerpts from 1995 Drug Prospectus Report, Criminal Intelligence Division, Maryland State Police

Cocaine

In the eastern region of the United States, a system for cocaine distribution exists, with New York City at the center of a "hub and spoke" distribution design. Cocaine destined for New York City arrives from all directions, including shipments moving to New York through Maryland.

Cocaine dealers from Maryland's larger cities travel to New York City to buy multi-ounce or pound quantities at the best possible prices. In the northern part of the State, lower level drug traffickers will obtain smaller quantities of cocaine in Philadelphia and Wilmington, Delaware. Likewise, dealers in the southern part of Maryland obtain cocaine from sources in Miami and Los Angeles.

Once back in Maryland, these dealers distribute ounce and multi-gram quantities of cocaine to smaller municipalities via the major highways: Interstate 95 from Baltimore, Route 13 from Salisbury, Routes 50 and 301 from Cambridge, Interstate 70 from Frederick and Hagerstown, and Route 68 from Cumberland. Recent drug arrests, however, indicate that traffickers may be switching to alternate, less traveled routes to avoid heavy law enforcement interdiction efforts on the major highways.

Prospective traffickers from New York also come to Maryland to sell cocaine and learn the trafficking trade. In this way, they can gather funding, establish supply contacts, and hone their business skills in a less ferocious dealing environment than New York City. If, in time, they have the opportunity to become dealers in the overcrowded New York drug market as well, they can easily extend the range of their already established and functioning trafficking networks northward.

The problem of New Yorkers venturing into Maryland to sell drugs has been mentioned in several law enforcement reports. The Criminal Intelligence Section of the Baltimore City Police Department noted in a report in fall 1992 that the agency first observed New Yorkers in a 1987 Baltimore cocaine trafficking investigation involving the Charles "Chucky" Pierce organization. In December 1991, a questionnaire circulated to all Baltimore patrol districts showed four of the nine districts exhibiting a significant influx of New Yorkers. The highest level quoted was in the southwestern district, where 45 to 50 percent of the drug activity at that time could be directly attributed to New York dealers. The northwestern, southeastern, and southern districts also reported the impact of New Yorkers. Both the northwestern and southeastern districts reported that 16 to 20 percent of their drug-dealing activity could be ascribed directly to New Yorkers, while the southern district reported that 6 to 10 percent of drug activity came from New Yorkers. It was also noted that, while the percentage of drug arrests involving New Yorkers stayed constant at about 2 percent of the total Baltimore drug arrests from 1986 to 1991, the actual number of New Yorkers (not including locals working for New Yorkers) arrested each year during that time span had increased nearly 200 percent. At that time, cocaine was the primary drug sold by New Yorkers, making up 54 percent of the cases, while heroin (22 percent of the cases) and marijuana (18 percent of the cases) dealing trailed.

In 1992, a report by the Wicomico County Narcotics Task Force in Salisbury, Maryland, indicated that, since 1988, the county had been inundated by New York dealers traveling to their area to sell drugs, primarily crack cocaine.

This migration of New York dealers purportedly supplanted and displaced the Haitian/Jamaican cocaine-dealing organizations that had dominated the market before that time, reducing these Caribbean traffickers to dealing on the outskirts of the drug community.

Finally, in 1992, the Maryland State Police (MSP) Criminal Intelligence Division issued a report noting the influence of New York drug dealers on a number of localities within the State. Data emerging from Frederick City were of particular interest. Of the 1,096 persons arrested for drug violations in 1990 and 1991, 48 gave New York residence addresses while another 140 listed New York as their place of birth. Of the 188 drug arrests with New York references, 124 of the arrestees, almost 66 percent of the total, were 30 years old or less at the time of arrest.

Much of the information about wholesale prices, payments to underlings, and other ancillary expenses attached to facilitating cocaine dealing is derived from anecdotal data acquired from apprehended individuals. Like all underground enterprises, the cocaine trafficking trade does not freely reveal its profit margins, expenses, and methods of operation. Thus, arrestees exaggerate their success, inflate their earnings, and magnify their images as master hustlers and street entrepreneurs. Despite the lack of credibility of some of these sources, one can gain some insight into the profitability of the drug business. One hears how a 19-year-old ex-street dealer made \$5,000 in one day selling drugs in the Lexington Terrace Housing Project in Baltimore. In another example, a kilogram of cocaine purchased wholesale in 1991 for \$18,000 in New York City generated \$50,000 in street sales in Baltimore. In 1991, 40 percent of the gross sales gained from vending that kilogram of cocaine in Baltimore went to street salesmen, leaving the dealer a profit of about \$10,000. Using this store of anecdotal information with the most recent average user/dealer prices, it is possible to surmise costs and profits for present-day cocaine dealers and street salesmen in Baltimore as trafficking operations expand.

Heroin

On the East Coast, New York City is recognized as the principal debarkation point for heroin into the country. The majority of heroin coming to Baltimore appears to be from New York City, with Philadelphia as the second most frequent point of shipment. Virginia may be an intermediate transshipment point for New York heroin destined for Maryland. The Drug Price and Purity Reports covering a 2-1/2 year period (issued by the MSP Criminal Intelligence Division, Analytical Services Unit) show that the Northern Virginia area has had substantially higher heroin purity levels compared to Maryland. In addition, heroin purity changes between the two areas were found to move in concert. Purity increases/decreases in Maryland mirrored changes in Northern Virginia. This was corroborated by intelligence information revealing that traffickers were transporting heroin to Virginia by train, then sending it to Baltimore by bus.

Maryland's heroin supply certainly does not come from just New York and Philadelphia. In April 1993, three Maryland women were arrested with 13.2 pounds of heroin at the U.S. Customs station in Otay Mesa, California. A controlled delivery was initiated, and the women were allowed to complete the transaction at a Laurel, Maryland, apartment complex. In that incident, the suspects traveled from Dallas, Texas, to Amsterdam, Holland, then to Lagos, Nigeria, where the original heroin was allegedly purchased. Then they traveled to Mexico City, Mexico, and finally, journeyed to the Otay Mesa, California, checkpoint.

The following heroin demographic information for 1994 was extracted from the MSP Criminal Intelligence Division, Analytical Services Unit, database:

In 1994, 82 percent of the people investigated for heroin were males. Racial breakdowns revealed that 59 percent were African American, 37 percent were Anglo, 3 percent were Hispanic, and 1 percent were described as "other race." By

age category, 25 percent were 18 to 25, 19 percent were 26 to 30, 17 percent were 31 to 35, and 39 percent were 36 and over.

High-purity heroin (inhalation quality heroin generally at least 20 percent pure) averaged between 50 to 55 percent purity in 1994. This represents an increase from 44 percent purity found in 1993. In 1994, a 1-gram purchase of low-purity heroin averaged around \$67, while the same 1-gram purchase of high-purity heroin commanded about \$272.

High-purity heroin may account for the dramatic rise in the Baltimore metropolitan area Drug Abuse Warning Network (DAWN) statistics for emergency room admissions. In the first half of 1990, the estimated rate of heroin-related emergency room episodes in Baltimore was 30.1 per 100,000 population. By the end of 1993 this rate had increased to 133.1 per 100,000 population. The problem may be rooted in the mentality of the user who injects heroin. An addict is principally concerned with his or her next fix. If only high-purity, snortable quality heroin is available, the intravenous drug user will probably inject it, regardless of the consequences.

Street-level dealers may find it less time-consuming and possibly even safer to sell heroin versus crack cocaine. Crack is a quick acting drug with a high that may last as little as 30 minutes, while the effects of heroin last for hours. This means the crack dealer must be available to meet the constant demand for the drug while the heroin dealer can sell his product, leave an area, and engage in other activities. By limiting the time on the street, the dealer lessens his risk of arrest. Since crack addicts are typically more violent than heroin addicts, dealing heroin offers less physical risk to the dealer. The same is true for competing dealers. Crack dealers have been associated with the rampant violence that has occurred in many U.S. cities, while heroin dealing has been less violent.

Anecdotal information indicates that some cocaine dealers require a heroin purchase with a

cocaine purchase. It has not yet been established whether this marketing method is being used to hook new heroin users, or if it is related to the user population that "speedballs" (injects cocaine and heroin mixed together). One trend that appears to be on the rise is that of the drug user who smokes crack and then snorts heroin to lessen the crash resulting from the cocaine high.

It is also important to understand the nature of heroin addiction. While cocaine abuse causes user burn out in a relatively short period of time, heroin addiction can span years or even decades, thus ensuring long-term customers.

Marijuana

Marijuana cultivation is a lucrative enterprise, and Maryland's geographic location and climate are conducive to growing the illicit crop. Indoor and outdoor grows can be found throughout the State. To counter this problem, the State with the support of the Bureau of Justice Assistance and DEA, has established a Marijuana Eradication Program that involves the combined efforts of State, county, and local police agencies and the Maryland National Guard. These eradication efforts are conducted through aerial and ground operations and result in a sizeable number of arrests and large marijuana seizures. The 1991 Marijuana Eradication Program set a record for marijuana plant seizures, a total of 11,210 plants. Plant seizures in subsequent years have shown a decline; however, this downturn may be accentuated because of the extremely successful 1991 eradication campaign.

In 1994, outdoor plant seizures declined because of several factors. First, a 20 percent decrease in helicopter flight time resulted in fewer plants being located by air. Secondly, a heat wave in early spring and a lack of rain killed many seedlings; consequently, eradication team members encountered many empty gardens. In addition to the plant seizures, 23.2 pounds of bulk processed marijuana were seized at outdoor grows in 1994, a significant decrease from 1993, when 75 pounds of processed marijuana were seized.

Although relatively small in number, seizures from indoor marijuana grows in Maryland have increased steadily since 1990. Seizures of bulk processed marijuana at these indoor growing operations have also increased significantly. In 1994, 88.3 pounds of processed marijuana were seized, versus 24.5 pounds in 1993. Officers making these indoor seizures frequently encounter sophisticated equipment used to raise the delta-9-tetrahydrocannabinol (THC) levels in the plants and increase the volume of marijuana produced per plant.

Occasionally, officers discover an indoor marijuana grow that is so small that it is deemed for personal use. However, the vast majority of indoor grows found in Maryland are large enough to supply high-grade marijuana for commercial sale. Statistics for indoor seizures in Maryland revealed an average of 39 marijuana plants per grow. The wholesale price of commercial-grade marijuana averages approximately \$1,800 per pound, while high-quality sinsemilla can sell for almost twice that amount. Currently, yield studies indicate that each marijuana plant is capable of producing 1 pound of marketable marijuana, so a modest 10-plant grow could generate at least \$18,000 in sales. Thus, an indoor grow as small as 10 plants still affords the opportunity to make substantial profits when production yield and quality are optimized.

Although an extended decline in marijuana use has been evident, marijuana has never vanished from the drug scene. Other more exotic or currently newsworthy drugs have simply overshadowed it. Now the negative social image of cocaine may be contributing to a resurgence in the popularity of marijuana. The constant publicity, education, and exposure regarding the dangers of cocaine addiction may have influenced some users to seek a "softer" alternative. Moreover, the much stiffer legal penalties attached to crack and cocaine trafficking may well be an impetus for some drug traffickers/dealers to switch to marijuana sales.

According to information extracted from the MSP Criminal Intelligence Division, Analytical

Services Unit data base, casual use of marijuana appears to be on the rise. In Maryland between 1993 and 1994, there was a 27 percent increase in persons arrested for user quantities of marijuana (1,553 in 1993 and 1,969 in 1994). Males comprised 85 percent of these arrests. By race, 74 percent of these individuals were Anglo, 25 percent were African American, and 1 percent were of another race. By age category, 14 percent of these marijuana users were under 18, 43 percent were between 18 and 25, 16 percent were between 26 and 30, 13 percent were between 31 and 35, and 14 percent were 36 or older.

Young people are becoming more inclined to view marijuana as harmless. Contributing to this perception is the overt promotion of the drug by rock, hip-hop, and heavy metal musical groups. These groups advocate marijuana use through their music and frequently use their popularity and media exposure to express pro-use/legalization views. Organizations advocating marijuana legalization use music concerts as a venue to solicit support, setting up booths and distributing propaganda on the benefits of the drug and the rights of the user. For example, promoters for a New Year's Eve "rave party" in Baltimore County used an advertisement with Uncle Sam displaying a marijuana leaf in his lapel.

Contributing to the resurgence of marijuana in the Baltimore-Washington area is the use of "blunts." A blunt is an inexpensive cigar, typically a "Philly Blunts" brand cigar, that has been split open and emptied of tobacco. Marijuana is substituted for the removed tobacco, and the exterior tobacco leaf of each cigar is used to rewrap the new contents. Use of blunts began in New York or Philadelphia and spread south, first to the Washington metropolitan area and then to Baltimore City. Reflections of this trend can be noted on clothing such as hats, T-shirts, and sweatshirts with characters who wear dreadlock hairstyles and declare their preference for blunts. In 1992, a feature article in *High Times* magazine described the assembly of blunts; an article in 1993 highlighted the history of the trend.

Drug use is cyclical in nature, and marijuana use appears to have reached the bottom of its most recent ebb in usage. Statistics and anecdotal information suggest that fads and marijuana use as an alternative to other drugs may be refueling a resurgence. Although law enforcement wins frequent battles against marijuana organizations, the massive number of smugglers involved and the diversified systems used to manufacture and distribute marijuana overwhelm law enforcement's efforts. With no foreseeable major interruption in supply and a predicted rise in the number of users, the status of marijuana as the most abused drug will probably rise.

Appendix H-2: Additional Drugs of Abuse Reported by Criminal Intelligence Division, Maryland Department of State Police

PCP

The availability and use of phencyclidine (PCP) appears to be stable. The bulk of PCP arrests are made in southern Maryland. Highway interdictions involving PCP in 1994 were common in Prince George's, Anne Arundel, and Charles Counties. Historically, Prince George's County is known as a vending site for PCP, with most of the drug entering the county from Washington, DC.

U.S. Drug Enforcement Agency (DEA) intelligence reports that PCP is generally transported from southern California to the Washington, DC, area in gallon and 3-gallon quantities in luggage via bus or airplane.

Average PCP prices in Maryland have fluctuated over the past 3 years. In 1992, an ounce of liquid PCP sold for about \$365 and declined to \$320 in 1993. In 1994, an ounce of liquid PCP sold for between \$350 and \$400. The decrease in price for PCP may have been the result of larger amounts of this drug reaching the streets.

One liquid ounce of PCP can produce 4 street ounces of treated parsley flakes. Each street ounce of parsley can be divided into 8 film canisters. A single film canister is the usual user purchase amount and sells for \$50 on the street. Therefore, after an initial investment of \$300, the dealer can realize up to \$1,300 profit from sales of PCP-treated parsley.

Dealers in Washington, DC, predominately African American males, continue to control the wholesale market for PCP. However, over 80

percent of individuals encountered in Maryland highway interdictions and investigations involving PCP in 1994 were Anglo. Anglo Marylanders travel to Washington, DC, to purchase liquid PCP from African American wholesalers, and return to Maryland to resell the drug locally in street-level quantities.

PCP is usually marketed in two ways. The drug is sprayed on parsley flakes ("greens") or marijuana ("love boat") and is sold in film canisters containing roughly 2.5 grams each. The treated parsley or marijuana is then smoked. In another use method, liquid ounces of PCP are sold in vanilla extract bottles, and tobacco or marijuana cigarettes are dipped into the liquid. These treated cigarettes, called "dippers," "sherman sticks," or "illies," can be purchased for approximately \$20 each.

No other new sales trends for PCP have been reported in Maryland. However, reports from Washington, DC, indicate that, in street jargon, PCP is known as "water." Another trend is PCP laced with gasoline. Called "octane," this variety of PCP is also being used for "dippers" and for treating parsley.

LSD

Lysergic acid diethylamide (LSD) continues to be a popular drug among high school and college-aged individuals. Circulated in high schools, on college campuses, at nightclubs, or teen and young adult parties, this hallucinogen appeals to the younger market because it is easy to obtain, cheap to purchase, and produces a high lasting up to 12 hours.

According to DEA intelligence information, LSD, or "acid," can be found in virtually every State in the nation. LSD is sold in a variety of forms at the retail level, including blotter paper, gelatin squares ("windowpanes"), sugar cubes, and small pills ("microdots"). In Maryland, blotter paper is the most common form of LSD.

Both retail and wholesale LSD prices have increased minimally over the past few years. State and local undercover agents usually purchase LSD at retail levels in quantities of 100 dosage units or less.

Maryland State Police Statewide LSD Prices
LSD prices have increased for street-level dealer quantities of 50 to 100 dosage units. However, prices for user quantities (1 to 5 dosage units) have remained stable over the past 3 years.

In January 1993, a new form of LSD was purchased during an undercover operation by the Maryland State Police (MSP), Drug Enforcement Division, in southern Maryland. This LSD was in the most common form for LSD in Maryland, blotter paper. However, the perforated doses, or "hits," measured twice the normal size, approximately 1/4 inch square. A picture of a cartoon pig dressed in overalls was imprinted on each hit. This was the first appearance of this type of LSD in Maryland.

Recently, another type of blotter acid has become popular in central Maryland. The blotter paper containing the LSD is orange in color and is imprinted with a picture of a sun with a human face covering each four square blocks of paper. The street name of this LSD is "orange sunshine" (not to be confused with the microdot form of "orange sunshine" LSD popular in the 1960s). In October 1993, the MSP Metropolitan Area Drug Task Force seized over 1,400 dosage units of "orange sunshine" in College Park, Maryland. "Orange sunshine" has also been sold in Baltimore County and Baltimore City.

Methamphetamine

Methamphetamine, known as "meth," "speed," and "crank" on the street, is a synthetic stimulant. Methamphetamine powder, often packaged in capsules or zip lock baggies, can be swallowed, snorted, or dissolved in water and injected. A very pure and potent form of methamphetamine, known as "ice," can be smoked.

Historically, methamphetamine has been associated with outlaw motorcycle gangs. Meth has not been prevalent in Maryland because of a decline in the activity of this major trafficking group in the State. However, recent information suggests that methamphetamine may be gaining in popularity among new and younger users in Maryland. Reportedly, the crystalline powder form of methamphetamine is readily available at rave parties and all-night dance parties frequented by juveniles and young adults, and can be purchased for \$20 a hit.

Several national indicators are also showing that methamphetamine use is on the rise. The DEA reports that, during the early part of 1995, the number of methamphetamine seizures as a result of highway interdictions has increased significantly around the country. Law enforcement agencies indicate that California is usually the source of methamphetamine being shipped to distribution/user markets throughout the United States.

According to Drug Abuse Warning Network (DAWN) Emergency Room data, between 1988 and 1991 the number of methamphetamine-related emergency room episodes decreased nationally. However, between 1991 and 1993, methamphetamine episodes increased 106 percent (from 4,900 to 10,100).

Methcathinone

Methcathinone, or "cat," first appeared on the illicit drug market near Marquette, Michigan, in January 1991. Since then, "cat" has spread

throughout the upper peninsula of Michigan and to other parts of Michigan and Wisconsin. Isolated reports of cat in Florida, Virginia, and Washington have been noted. In Maryland, there have been reports that persons have attempted to manufacture and market "cat" in Frederick County, but confirmation is lacking.

Methcathinone, a strong amphetamine-like substance, is known to be more potent than methamphetamine. "Cat" is easy to make and its precursor chemicals are readily available. As such, the manufacture of "cat" could become attractive to drug entrepreneurs. The DEA permanently listed methcathinone as a Schedule I Controlled Dangerous Substance (CDS) on October 15, 1993.

Maryland does not have a strong existing user population for methamphetamine or similar drugs, so "cat" may be slow to find a market here. However, law enforcement and legislators should be aware of this drug and the threat it poses if it starts to appear with any regularity in Maryland.

MDMA

MDMA (3, 4-methylenedioxymethamphetamine) is a hallucinogenic amphetamine. Also known as "ecstasy," "XTC," "X," and "Adam," it is not a prominent drug in Maryland. Popular among rave party attendees, it is sold in pill, capsule, or powder form and can be taken orally or snorted. One hit of the drug sells for between \$25 to \$45. MDMA seizures or undercover purchases have been made in Frederick County, Howard County, and Baltimore City. In two instances the drug was in tablet form and concealed inside Tic-Tac and Tylenol containers. Anecdotal information suggests that MDMA is finding its way to different areas of the State. It is believed that teenagers and young adults purchase small quantities of the drug at rave parties and return to their homes to sell the MDMA to friends and associates.

Sources in nearby Fairfax County, Virginia, reveal that MDMA is available and has been purchased from an Asian male. The MDMA was sold in capsule form at \$35 per capsule. The source of the MDMA has not been determined.

The Clarksburg, West Virginia, DEA office was involved in the arrest of four individuals connected with an MDMA clandestine lab operation. When seized, the lab contained about 4,000 ml of MDMA solution. Reportedly, the "cooker" of this solution has a bachelor's degree in chemistry.

Ketamine

Ketamine, or ketamine hydrochloride, is a legal tranquilizer used in veterinary medicine. Chemically related to phencyclidine (PCP), it is sold as an injectable under the brand names Ketacet and Ketajet. For human consumption, ketamine is marketed under the name Ketalar. Ketalar is a rapid-acting general anesthetic that is mostly used for diagnostic and short surgical procedures.

Ketamine has been diverted into the illicit market from veterinary sources and is called "Special K" or "cat Valium" on the street. Normally found in injectable form, it is converted into a powder and repackaged in small zip-lock baggies or capsules. Sold for \$20 a dosage unit or "hit," ketamine is generally snorted. While ketamine acts as a tranquilizer in animals, it has hallucinogenic effects on humans. Ketamine can cause convulsions, especially when taken in large dosages. Some users experience vomiting when mixing it with alcohol. The drug can cause a depressed person to become suicidal or an agitated person to become violent.

Ketamine has been common in the New York night club scene for many years. In the Baltimore metropolitan area "Special K" is readily available at rave parties.

According to the American Veterinary Medical Association, ketamine can only be obtained by licensed veterinary clinics and research institutes. Last summer, the Virginia Veterinary Medical Association reported a scam to obtain ketamine. A person would call a veterinary hospital or clinic, saying they were from another doctor's office. They then stated that they had run out of ketamine and wanted to borrow a bottle until their order came in. This scheme was reported in Virginia, Maryland, and North Carolina. Heightened awareness among veterinary clinics has resulted in tighter controls on ketamine supplies and, as a result, traffickers are resorting to more drastic measures to obtain the substance. In February 1995, three subjects committed an armed robbery at a Carroll County veterinary hospital and stole bottles of ketamine. In June 1995, a veterinary clinic in St. Mary's County was broken into and 33 bottles of ketamine were stolen.

In some States, ketamine is controlled, but in most States it is only restricted. Because of the drug's high potential for abuse, it is under consideration for an official controlled substance classification, based on police and medical information.

Drugs Used at Raves

Rave parties, also known as underground or after-hour parties, are all-night dance parties held at night clubs, warehouses, and parks. Disc jockeys from New York, Philadelphia, Baltimore, and Washington, DC, travel up and down the eastern seaboard to play the "techno music" heard at these gatherings. The music, accompanied by laser and strobe light shows, is loud and characterized by a fast, pulsating beat. Large rave parties are considered to be special events and are very popular and well-attended by young people. It is not uncommon for people to travel 4 or 5 hours to attend one of these parties.

Most rave party goers are high school and college students ranging in age from their late teens to early twenties. Ravers in the Baltimore-Washington area are predominantly Anglo; however, some rave parties are described as melting pots for young people from different economic and racial backgrounds. The clothing styles are mostly retro 60s and 70s psychedelic colors, bell-bottoms, platform shoes, and bizarre hats but loose-fitting shirts, shorts and pants, and baseball hats worn backwards are also popular. Raves are a forum for the "X" generation, a place to release frustrations and be rebellious.

The promoters of rave parties advertise via flyers (usually index card sized with psychedelic designs), private mailing lists, e-mail, and by word of mouth. There is security at all rave parties, and the clubs that hold parties check identification at the door. A person must be 18 or over to attend a rave, but it is easy enough for high school students to acquire false identification to gain admittance. Some rave parties claim to be alcohol-free, others serve alcohol, and still others let participants bring their own. All sell non-alcohol drinks, especially sodas and "smart drinks," fruit juice drinks with vitamins, amino acids, and caffeine.

There are also smaller, private rave parties held at a variety of different locations. Alcohol is generally not served at these functions, and consequently, identification is not checked. Admission is by invitation only.

The most prevalent drugs at rave parties are LSD, MDMA ("ecstasy"), marijuana, cocaine, methamphetamine, ketamine ("Special K"), and nitrous oxide. It is difficult for law enforcement to mingle with the drug-users at rave parties because they generally hang out in cliques or tight-knit groups and are suspicious of outsiders.

Rave parties are distinguished from "house parties," which have a predominately African

American crowd. The popular drug at these club and social gatherings is marijuana "reefer" joints and "blunts," inexpensive cigars, especially "Philly Blunts," that are split open, emptied of tobacco, and filled with marijuana.

Prescription Drugs

Drug diversion is the act of obtaining legal prescription drugs for illicit purposes. Such drugs are diverted into the illicit market by prescription forgery and phone-in prescription fraud, by falsifying symptoms in order to obtain prescriptions ("doctor shopping"), and by unscrupulous practices of professionals such as doctors, nurses, dentists, and pharmacists. Hospitals and pharmacies are also the target of thefts by burglars and by employees themselves.

Diverted pharmaceutical drugs are popular for a variety of reasons. First and foremost, quality control is employed during drug manufacture and the user knows that each dose will be consistent and the effects will be the same. Easily recognizable, prescription drugs are usually imprinted with a drug name or a drug company symbol. These drugs are also relatively cheap and easy to obtain. Unlike illicit drugs, they can be purchased through prescription plans, Medicare, or medical assistance. Finally, the abuse of prescription drugs generally goes undetected because police either have few resources to tackle the problem or are not well informed about drug diversion. Prescription drugs in Maryland continue to be trafficked primarily by Anglos in their early 20s to late 40s. The following are the commonly diverted drugs:

- Dilaudid (hydromorphone, Schedule II), a narcotic analgesic
- Percocet/Percodan (oxycodone, Schedule II), a narcotic analgesic
- Xanax (alprazolam, Schedule IV), a tranquilizer
- Valium (diazepam, Schedule IV), a tranquilizer

- Vicodin, Lorcet, Lortab, Anexsia (hydrocodone, Schedule III), narcotic analgesics and antitussives
- Doriden (glutethimide, Schedule II), a depressant
- Tylenol with Codeine Tylenol 3 or 4 (codeine phosphate, Schedule III), an analgesic.

DEA drug diversion units in the Baltimore-Washington area also report that clonidine (brand name Catapres), a non-controlled drug used to manage hypertension, is being used as a booster with narcotics, narcotic analgesics, and sedatives such as heroin, methadone, Darvocet, Valium, and Xanax.

A DEA system that tracks the wholesale movement of pharmaceuticals shows that, in 1993, Maryland ranked number one per capita in the nation in shipments of oxycodone. In 1992 Maryland ranked third. An increase was also seen with Doriden, a depressant, which ranked eighth in 1992 and rose to second in 1993. Although there is a large heroin population in Baltimore, Maryland, dropped from seventh place in 1992 to thirteenth in 1993 for hydromorphone (Dilaudid), a narcotic analgesic. These three drugs are readily available on the street in Maryland.

The DAWN emergency room sample for the Baltimore metropolitan area showed significant decreases between the first two quarters of 1992 and the first two quarters of 1993 for the following prescription drugs reported by participating hospitals: alprazolam (Xanax, a tranquilizer), diazepam (Valium, a tranquilizer), d-propoxphene (Darvon, a narcotic analgesic), fluoxetine (Prozac, an antidepressant), cyclobenzaprine (Flexeril, muscle relaxant), and naproxen (Naprosyn, an analgesic).

Approximately 5 percent of admissions to Maryland treatment facilities in FY 94 reported a prescription drug or an over-the-counter drug as

a substance of abuse. Among those admitted, pharmaceutical drugs (non-prescription methadone, barbiturates, sedatives, amphetamines, tranquilizers, and over-the-counter drugs) increased slightly from 2,843 in FY 93 to 3,011 in FY 94. Because treatment centers report only the top three substances cited as substances of abuse by each client, it is possible that prescription drug abuse by Maryland residents is underestimated in persons using multiple illicit drugs.

Inhalants

The term "inhalants" refers to a wide array of chemicals, including solvents, aerosols, gases, and volatile nitrites, which, when drawn into the lungs, induce a temporary euphoric state. The majority of these chemicals are legal to purchase and possess. In fact, many are contained in common household items such as cleaning fluids, glue, nail polish remover, spray paint, lighter fluid, and gasoline.

Inhalants are inhaled, or "huffed." Some of the more common ways to huff are directly from the container, from a soaked rag, or after the substance has been transferred into another container such as a soda can or plastic bag. Many are not aware of the potential dangers of this form of abuse. Inhalants can cause physical changes such as double vision, dizziness, loss of coordination, and blackouts. These effects are usually temporary; however the misuse of these substances can damage the heart, lungs, brain, liver, and kidneys. High concentrations of these substances can also cause death by suffocation or cardiac collapse from shock.

Inhalant abuse has been popular among school-aged children for many years, and recent reports indicate that the frequency of abuse is on the rise. The 1993 Monitoring the Future Survey reported that, after alcohol and tobacco, inhalants are the most abused substances among eighth-graders. According to the survey, almost one in

five eighth graders has used inhalants. The 1992 National Household Survey on Drug Abuse indicates that, for lifetime use, gasoline and glue are the most abused inhalants among 12- to 17-year-olds, while amyl nitrites (poppers or snappers) and nitrous oxide are most frequently used by adults age 18 or over.

Law enforcement can offer little deterrence because most of these products are readily available and can be purchased by anyone. Moreover, the charge for illegally selling inhalants is usually a misdemeanor. It is not surprising, then, that incidents of inhalant abuse are becoming more common.

In Maryland and elsewhere, there is a growing problem in the sale and abuse of nitrous oxide gas. Nitrous oxide is a colorless, sweet-smelling gas that has a variety of uses. In the medical profession, nitrous oxide, known as "laughing gas," is most commonly used for minor oral surgery and dental work. This gas also has a number of industrial uses. It is used as a propellant in aerosol food cans and is sold commercially in small canisters or cartridges called "whip-its," which are marketed under various brand names such as Whippets and EZ Whip and used to make whipped cream. Nitrous oxide is also sold in cylinders or tanks for medical and dental use. Nitrous oxide with hydrogen sulphide or another gas added is used as a fuel enhancement in race cars.

There has been a growing concern by many in the medical profession, government, and industry about an increase in the abuse of nitrous oxide. Theft of cylinders from suppliers and medical sources and the deliberate purchase of tanks from distributors who are oblivious to its misuse has made nitrous oxide available to many persons. Some are entrepreneurs who seek to profit from its misuse while others are juveniles or young adults looking for a cheap high. At concerts, people will openly sell a dose of nitrous

oxide, known as "hippie crack" or simply "nitrous," for approximately \$2 to \$5. The gas is generally dispensed from a large nitrous oxide tank into a balloon. The captured gas is then sucked through the mouth in the same manner as some draw in helium to make their voices change.

Concert goers, however, are not the only ones lured into taking part in this activity. In the summer of 1992, police officers from the Wilkens precinct of the Baltimore County Police Department arrested two young men on separate occasions for allegedly selling balloons of nitrous oxide for \$2 to \$3 each to kids on the street.

Not just a local phenomenon, there are numerous news accounts of nitrous oxide-related incidents across the country. Some news reports describe motor vehicle accidents where not only drivers under the influence of nitrous oxide were injured or killed, but also pedestrians. Other articles recount the deaths of juveniles that were not aware of the hazards of inhaling this potentially lethal substance. Special dangers include using the gas in a closed environment, such as a car, where all the oxygen is expelled, or where an

anesthesiological mask is used that stays attached to the face even if the user passes out, or explosion of the tank.

Many who abuse nitrous oxide believe that it is a "safe" (harmless, nonaddictive and undetectable) drug. However, taken in combination with prescription or over-the-counter medicines or any street drugs, anesthetics such as nitrous oxide can have serious side effects or can be fatal. In addition, the doses or "hits" of nitrous oxide purchased on the street may not be medical grade laughing gas, but rather an industrial grade of the gas used in race cars, with many harmful impurities such as sulphuric acid, ammonia and nitric oxide.

According to law enforcement, there is a huge profit motive for selling nitrous oxide. One large compressed gas cylinder contains between 14,000 to 16,000 liters of nitrous oxide. A typical street sale involves a 2- to 3-liter balloon of nitrous oxide, which sells for anywhere between \$2 and \$5. One 14,000 liter tank could inflate approximately 4,700 balloons. Even at the more conservative price of \$3 per balloon, the profit potential from one large cylinder is \$14,100.

Appendix I: Ethnographic Studies

Atlanta

An ethnographer in Atlanta developed a short-term ethnographic project to determine why female crack users were increasingly being arrested but were not being treated in hospital emergency rooms or admitted to drug abuse treatment programs. This was an important question because the indicator data from all three sources (police, hospitals, and drug abuse treatment programs) were being used to assess the nature and extent of drug abuse problems.

The ethnographic team in Atlanta already had substantial experience in the city. In addition to interviews, they did participant observation in neighborhoods in which they had previously worked. They quickly learned about women in the crack scene.

Female crack users had previously been portrayed primarily as women who offer sexual services in return for small amounts of the drug. The ethnographers learned that most of the female crack users in Atlanta were not happy with this arrangement, and looked for other ways to support their habits in a more independent, less demeaning way. The solution for many of these users was to become crack dealers. In fact, some had moved into higher level positions in the crack distribution network.

As women entered the crack-dealing business, they became more visible to law enforcement which, in turn, resulted in an increase in arrests. Once they were arrested and known as dealers, their arrests tended to repeat. This shift in positions in the crack scene thus resulted in increase of women in the arrest statistics.

But why were these women not being seen in drug abuse treatment programs and hospital emergency rooms? First, they criticized local drug treatment programs for their "male" orientation. One issue was the lack of child care.

Many refused to consider drug abuse treatment because they would have to leave their children for extended periods of time. A more diffuse issue had to do with what they called "male" treatment styles.

The crack-using females talked about why they avoided the emergency room as well. The issue of child care came up here, but more importantly, women felt that if they went to an emergency room, they would be labeled as "drug addicts" and the label would increase their chances of being arrested once they were back on the streets. They wanted to avoid this label, especially since the police were increasing efforts to arrest crack users and dealers.

Conducting a short-term ethnography, the Atlanta researchers were only able to tap the surface of this issue, but they did obtain some useful information to help understand the differences that were being seen in the indicator data. The epidemiologic indicators turned out not to be a puzzle at all. Instead, the indicators reflected a shift in behaviors. More and more, the women were turning to drug dealing and feeling negatively about treatment facilities.

Philadelphia

With the support and interest of the city health services, an ethnographer in Philadelphia conducted a study of the city's Puerto Rican community. The question was, "Why don't more Puerto Rican heroin addicts use treatment services?" Arrest data showed that a relatively high percentage of Hispanic arrestees had used illicit drugs.

The Philadelphia ethnographer, who was already well known for her work with needle exchange, went into the community to interview and observe. In a relatively short period of time, she learned why Puerto Rican heroin addicts were less likely than addicts in other racial/

ethnic groups to use treatment services. First, an obvious language problem existed. Many of the interviewees could speak English well, but experienced difficulty expressing emotional problems and needs. In a fast-paced therapeutic environment, many felt that there was no point in seeking treatment where communication was so difficult.

A second issue had to do with the boundary between the streets and treatment. It was learned that entering and leaving treatment was more of a social than an individual act. Among interviewees, the ethnographers found greater treatment success when an addict had family support in physically entering a treatment program and then when leaving it and returning to the community. In the Anglo-American model, the individual shows up, and once treatment is finished returns to the community and starts a new life. This lack of social support in the transitions was often mentioned by Puerto Ricans as problematic.

A third issue related to sources of information about different programs. The city used a variety of methods to market treatment services, but the most important source of information from the addicts' point of view was what they learned within their drug-using networks and in places where drug addicts congregate, like shooting galleries.

Many other issues were identified by the ethnographer, but these three language, social support during transition into and out of treatment, and source of program information exemplify the reasons Puerto Rican addicts were not taking advantage of treatment resources and not well represented in the treatment data set.

San Francisco

An ethnographer in San Francisco assessed risk factors for HIV transmission among needle-using addicts. The ethnographic team observed and interviewed a group of homeless men who lived under a freeway overpass in the city. One of their first conclusions was how often and how routinely users put themselves at risk for HIV. It

was quickly learned that there was one simple economic reason. The average cost for a street unit of heroin in that city is \$20. Seldom does an individual have that much money, so typically two to three addicts pool their resources. The primary type of heroin in San Francisco is Mexican Black Tar, which has to be dissolved before it can be divided. This means that, at the time of use, shares must be apportioned, and the measuring out process involves common implements or shared water and cotton. The economics of heroin, then, established conditions of HIV risk most of the time that the men used.

San Antonio

In San Antonio, an ethnographic team assessed the transmission and prevention of drug-use patterns in the family context among the Mexican-Americans in that city. Chicano addicts often explain use and relapse with the Spanish phrase *la presion*, the "pressure" in English. *La presion* is so taken for granted that community members have difficulty explaining what it means. Indeed, some ethnography consists of making such taken-for-granted aspects of life explicit in all their complexity. *La presion* signals a host of external events that can occur, often unpredictably, usually out of the person's control, that impact them and their lives in a negative way. Many of the problems that result are a function of poverty, since the Chicano addicts usually lead lives with no margin for such mistakes to occur.

Baltimore

In Baltimore, there was an interest in determining the relationship between (un)employment and drug abuse. An ethnographer in Baltimore conducted ethnographic interviews and spent time in the neighborhood around a homeless shelter. He found that some men, who had histories of casual and controlled drug use, had found work difficult to locate in Baltimore because of economic decline. The loss of employment had a deteriorating effect on family life, and drug use increased.

For most of the sample, the story was more complicated. Most of the men "juggled" different

identities and had done so for years. They worked, had families, and used drugs and alcohol in more or less serious ways. They had lived for years like this, pushing different work, family, and drug identities to the edge, then coming back to maintain the balance. For these men, employment mattered in a different way. With the economic downturn in Baltimore, it was not easy to find jobs anymore. Once an addict pushed a little too far over the edge in one job and lost it, others were difficult to find. But the problem was also the structure of the

Baltimore drug markets. With vertical integration and a shift to crack cocaine, the old neighborhood-based markets for heroin disappeared. The men lost their sources of supply and the new sources were more violent and impersonal than what they had known before. With the loss of jobs and the shift in the market, they found themselves in a world that no longer allowed them to use their experience to manage two kinds of identities work and drugs. They became homeless and turned up in the shelter.

Appendix J: Sample Format for State Reports

DRUG ABUSE PATTERNS AND TRENDS IN ALEXANDRIA/RAPIDES PARISH

Regional Office
State Office of Alcohol and Drug Abuse

Alexandria, Rapides Parish

Cocaine/crack and marijuana are the most serious illicit drug abuse problems in Rapides Parish and the City of Alexandria. In the period from January 1, 1996 through August 31, 1997, 59 percent (n=783) of the clients admitted to treatment programs for illicit drug use in Rapides Parish were primary cocaine/crack abusers; almost 63 percent were African-American (compared with 36 percent whites), 67 percent were male, and almost three-quarters (73.7 percent) were 30 years of age or over. Primary marijuana abusers accounted for almost 27 percent of the illicit drug abusers admitted to treatment. More than half (59 percent) were white (40 percent were African-American), 62 percent were male, and 73 percent were under 30 years of age. Twenty-nine people were admitted for primary methamphetamine abuse and only 9 for primary heroin abuse. Most of the methamphetamine abusers were white (55 percent) and male (62 percent). The 1996 Alexandria City Police Arrest Report provides further evidence of the cocaine/crack and marijuana problems. Of the 398 adult arrests for drug possession, 57 percent involved marijuana and 41 percent involved cocaine (including crack). Most of the adult marijuana (83 percent) and cocaine (83 percent) possession arrests were African-American. There also were 31 adult arrests for the sale or manufacturing of illicit drugs; 58 percent involved marijuana and 35 percent involved cocaine and 81 percent of those arrested were African-American. In addition, 82 juveniles were arrested for drug-related violations by the Alexandria police: 73 for drug possession and 9 for selling or manufacturing drugs. Most (93 percent) were African-American. Over two-thirds of possession arrests of juveniles involved marijuana; 27 percent involved cocaine.

INTRODUCTION

1. Area Description

Alexandria is located in central Louisiana. The population of the city is approximately 50,000 residents. About half the population is African-American and half is white. According to the 1990 census, 54 percent of the population are females. Because the city is located in the center of the State, treatment programs draw people from other areas of the State.

2. Sources of Data

- **Treatment Data**—Rapides Parish Drug Abuse Treatment Admissions Data were provided by the State Office of Alcohol and Drug Abuse for the period from January 1, 1996 through August 31, 1997.
- **Rapides Parish Coroner's Office**—Coroner's reports provided information

on deaths with positive tests for alcohol and/or drugs.

- **Rapides Regional Medical Center**— This facility reported emergency department drug-related incidents but could not provide information about the specific drugs used.
- **Marshal's Office, City of Alexandria**— The Marshal's Office provided data on substance-abuse related arrests and convictions for motivation (disturbing the peace), possession of drug paraphernalia, and possession of marijuana.
- **Metro Narcotics Task Force**— This task force provides data on drug-related arrests by race/ethnicity.

- **Alexandria City Police (FBI Arrest Report)**—This report covers arrests for drug violations including the manufacturing/sale and possession of different drugs by ethnicity.
- **Louisiana Adult Household Survey**— Alexandria was included with Shreveport in this Statewide survey.
- **1996–1997 Adolescent Survey on Pathological Gambling and Substance Abuse**—Data from this survey represent 417 youth in Rapides Parish. (Sample sizes for different questions vary because of branching patterns in the questionnaire.)

DRUG ABUSE PATTERNS AND TRENDS

1. Treatment Data

Cocaine/crack accounted for 31.1 percent of all treatment admissions in Rapides Parish during the period from January 1, 1996–August 31, 1997, and for 59.3 percent of admissions for primary abuse of an illicit drug. Almost two-thirds of the primary cocaine/crack admissions were men, 62.8 percent were African-American, and 73.7 percent were age 30 or older (exhibit 1).

Marijuana accounted for 14 percent of all admissions, and for 26.6 percent of admissions for primary abuse of an illicit drug. Nearly three-fourths of the (primary) marijuana abusers were male, 59.4 percent were white, and 73.5 percent were age 29 or

younger, with 38.9 percent being under 20 years of age.

Nine admissions were for primary abuse of heroin; the majority were male, white, and age 30 or older. There also were 29 admissions for primary abuse of methamphetamine; the majority were male, white, and age 30 or older, although 12 (41.4 percent) were under age 30.

2. Drug-Related Emergency Department Admissions

The Rapides Regional Medical Center reported 150 drug-related emergency department admissions in 1996. Data on the specific drugs were not available.

3. Drug-Related Deaths

The Rapides Parish Coroner's Office reported 11 alcohol-related and 2 drug abuse-related deaths in 1997. The types of drugs used were reported as "unknown." One drug-related death involved an accident, the other a homicide.

4. Drug-Related Arrests

- **Marshal's Office, City of Alexandria**

The Marshal's Office reported 157 arrests and 140 convictions for the possession of drug paraphernalia in 1996. In addition, there were 221 arrests and 205 convictions for marijuana possession (exhibit 2).

- **Metro Narcotics Task Force**

In 1996, the Narcotics Task Force reported 229 drug-related arrests (exhibit 3). Of those arrested, 77.3 percent were African-American, and 21.4 percent were white (1.3 percent were of other ethnic backgrounds). Of the African-Americans, 83 percent were males. Of the white arrestees, 59 percent were male and 41 percent female.

- **Alexandria City Police**

The Alexandria Police Department reported 429 arrests of adults for drug-related violations in 1996. The vast majority were male (89.3 percent) and African-American (82.7 percent). There were 163 arrests for possession of cocaine and 11 for the manufacture/sale of cocaine, as well as 227 arrests for marijuana possession and 18 for the manufacture/sale of marijuana. Relatively few of the 1996 arrests involved other drugs. There were five arrests for the possession of synthetic narcotics and one for the manufacture/sale of

synthetic narcotics. There were three arrests for the possession of other non-narcotic drugs and one arrest for the sale/manufacturing of these drugs (exhibit 4).

Partial data reported for the January 1 through August 31 period showed that marijuana and cocaine continued to be the most serious drug problems among adult arrestees. There were 95 arrests for marijuana possession and 23 for cocaine possession (exhibit 4).

In 1996, 82 juveniles were arrested for drug violations; most of the juveniles (92.7 percent) were African-American. Fifty youngsters (48 boys and 2 girls) were arrested for marijuana possession; two boys were arrested for the manufacture/sale of marijuana. In addition, 20 (18 boys and 2 girls) were arrested for cocaine possession, and 7 (African-American males) for the manufacture/sale of cocaine (exhibit 5).

The data for the first 10 months of 1997 showed similar arrest patterns. There were 19 arrests of juveniles for marijuana possession and 3 marijuana manufacture/sale arrests; all were male. There were eight arrests for cocaine possession (7 were male and 7 were African-American; see exhibit 5).

5. 1996 Louisiana Adult Household Survey

As noted earlier, Alexandria and Shreveport were included together in a region in this survey. This area had the highest rate of heavy alcohol use (10.2 percent of the respondents) and the lowest rate of core illicit drug use (4.7 percent) during the year prior to the survey. ("Core" drugs are marijuana/ hashish, hallucinogens, cocaine/crack, and heroin/opiates.)

6. 1996–1997 Statewide Adolescent Survey

A total of 417 adolescents from Rapides Parish were included in the survey. Almost 66 percent were female, 69 percent white; the mean age of the youth was 14.30. Most (61 percent) had consumed a full drink of alcohol and 47 percent had, reportedly, been drunk. Almost 25 percent had been drunk monthly, weekly, or daily in the last 12 months. The drugs reported as ever used by the youth included marijuana (26.9 percent), narcotics other than heroin (11.5 percent), inhalants

(12.9 percent), hallucinogens (8.6 percent), amphetamines (6 percent), cocaine/crack (4.8 percent), and heroin (3.1 percent; see exhibit 6).

7. Field Data

There is some evidence that youngsters are injecting crack. Intravenous crack use has been reported, each week, by two to three people entering detoxification in Alexandria. A few years ago, field reports indicated that youngsters were mixing crack with lemon juice to melt the crack) and injecting it.

EXHIBIT 1

TREATMENT ADMISSIONS BY PRIMARY DRUG OF ABUSE, AGE AT ADMISSION, RACE/ETHNICITY AND PERCENTAGE—RAPIDES PARISH

Drug Variable	Cocaine/ Crack	Heroin	Marijuana/ Hashish	Methamphetamine	Alcohol	Other Drugs/ No Data*
Number	(783)	(9)	(352)	(29)	(1,199)	(148)
Primary Drug	31.1	0.3	14.0	1.1	47.6	5.9
Age at Admission						
<20	2.7	0.0	38.9	20.7	6.7	12.8
20-29	23.7	12.5	34.6	20.7	23.2	37.9
30-39	50.7	50.0	21.7	34.5	37.4	33.1
40+	23.0	37.5	4.9	24.1	32.6	16.2
Race/Ethnicity						
Caucasian	36.4	66.7	59.4	55.2	61.9	90.0
African-American	62.8	33.3	40.3	44.8	37.6	9.4
Other	0.8	0.0	0.3	0.0	0.5	0.6
Gender						
Male	66.7	66.7	75.3	62.1	74.1	47.3
Female	33.3	33.3	24.7	37.9	25.9	52.7

N=2,520

* No Data=33

SOURCE: Louisiana State Office of Alcohol and Drug Abuse, January 1, 1996–August 31, 1997

EXHIBIT 2

NUMBER OF DRUG-RELATED ARRESTS AND CONVICTIONS—
CITY OF ALEXANDRIA, MARSHAL'S OFFICE, 1996

Charge	Arrested	Convicted
Disturbing the peace by intoxication	347	331
Possession of drug paraphernalia	157	140
Possession of marijuana	221	205
Total Number	725	676

SOURCE: City of Alexandria, Marshal's Office

EXHIBIT 3

GENDER AND RACE/ETHNICITY OF PERSONS ARRESTED
FOR DRUG-RELATED OFFENSES BY THE METRO
NARCOTICS TASK FORCE, 1996

Gender	Race/Ethnicity			
	African-American	Caucasian	Other	Total
(Number)	(177)	(49)	(3)	(229)
Male	64.2	12.7	0.9	77.7
Female	13.1	8.7	0.4	22.3

SOURCE: Metro Narcotics Task Force

EXHIBIT 4

DRUG-RELATED* ADULT ARRESTS BY TYPE OF ARREST, GENDER, AND RACE/ETHNICITY—
ALEXANDRIA CITY, 1996–1997**

Type of Arrest	Males		Females		African-American		White/Other	
	1996	1997	1996	1997	1996	1997	1996	1997
(Total Violations)	(383)	(108)	(46)	(16)	(355)	(81)	(74)	(43)
Sale/Manufacture								
Cocaine	11	0	0	0	10	0	1	0
Marijuana	17	0	1	0	15	0	3	0
Synthetic Narcotics	1	0	0	0	0	0	1	0
Other Non-Narcotics	0	0	1	0	0	0	1	0
Possession								
Cocaine	142	18	21	5	135	15	28	8
Marijuana	205	85	22	10	188	62	39	33
Synthetic Narcotics	5	3	0	0	5	3	0	0
Other Non-Narcotics	2	2	1	1	2	1	1	2

*Excludes alcohol-related arrests: 320 in 1996, 185 in 1997; 97 percent were DWI in 1996. All were DWI in 1997

**January 1–August 31, 1997

***“Other” includes only 2 persons charged with possession (1 cocaine, 1 marijuana) in 1996

SOURCE: Alexandria City Police FBI Arrest Report

EXHIBIT 5

NUMBER OF DRUG-RELATED* JUVENILE ARRESTS BY TYPE OF ARREST, GENDER, AND RACE/ETHNICITY—ALEXANDRIA CITY, 1996–1997**

Type of Arrest	Males		Females		African-American		White	
	1996	1997	1996	1997	1996	1997	1996	1997
(Total Violations)	(78)	(31)	(4)	(1)	(76)	(27)	(6)	(5)
Sale/Manufacture								
Cocaine	7	0	0	0	7	0	0	0
Marijuana	2	3	0	0	2	3	0	0
Possession								
Cocaine	18	7	2	1	19	7	1	1
Marijuana	48	19	2	0	46	17	4	2
Synthetic Narcotics	0	1	0	0	0	0	0	1
Other Non-Narcotics	3	1	0	0	2	0	1	1

*Excludes 8 alcohol-related arrests in 1996; 7 were DWI arrests

**January 1–August 31, 1997

SOURCE: Alexandria City Police FBI Arrest Report

EXHIBIT 6

SUBSTANCE USE AMONG ADOLESCENTS SURVEYED—RAPIDES PARISH

“Ever Tried”	Percent “Yes” (Rounded)
Marijuana	26.9
(Drugs other than marijuana)	(29.5)
Cocaine/Crack	4.8
Heroin	3.1
Other Narcotics	11.5
Tranquilizers	5.8
Hallucinogens	8.6
Amphetamines	6.0
Barbiturates	2.9
Over-the counter drugs	21.6
Someone else’s prescribed drug	12.7
Alcohol (a “full drink”)	61.4
Tobacco products	57.3
“Huffing” (sniffing drugs)	12.9
Ever Been Drunk	
Drunk in last 12 months	47.0
Monthly or more often	24.9
Mean	
Age first tried marijuana	13.55
Age at first drink (alcohol)	10.93
Age first drunk	12.50

N=147 full sample; 398–411 on substance abuse questions

SOURCE: Statewide Adolescent Survey on Pathological Gambling and Substance Abuse (6th through 12th grades) School Year 1996–97